FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008136

Facility Name: DOBSON PLAZA

Address: 120 DODGE AVENUE (Number) EVANSTON (City) 60202 (Zip Code)

County: COOK

Telephone Number: (847) 869-7744 **Fax #** (847) 869-1332

IDPA ID Number: 36-260166801

Date of Initial License for Current Owners: 10/15/66

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) CHARLOTTE KOHN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,641	12,076	1,730	32,447	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,641	12,076	1,730	32,447	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.65%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/15/66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 1,601

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	84,737	16,680	40,612	142,029		142,029		142,029			1
2	Food Purchase		125,262		125,262	(8,687)	116,575	(748)	115,827			2
3	Housekeeping	15,442	22,934		38,376		38,376		38,376			3
4	Laundry	60,205	10,631	1,791	72,627		72,627		72,627			4
5	Heat and Other Utilities			77,070	77,070		77,070		77,070			5
6	Maintenance	59,137	7,453	61,319	127,909		127,909	2,772	130,681			6
7	Other (specify):*			6,068	6,068		6,068		6,068			7
8	TOTAL General Services	219,521	182,960	186,860	589,341	(8,687)	580,654	2,024	582,678			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,495,620	60,140	7,678	1,563,438		1,563,438		1,563,438			10
10a	Therapy	13,635	1,438	26,683	41,756		41,756		41,756			10a
11	Activities	68,874	6,767		75,641		75,641		75,641			11
12	Social Services	20,978		3,840	24,818		24,818		24,818			12
13	CNA Training											13
14	Program Transportation			25	25		25		25			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,599,107	68,345	43,026	1,710,478		1,710,478		1,710,478			16
	C. General Administration											
17	Administrative	133,763			133,763		133,763		133,763			17
18	Directors Fees											18
19	Professional Services			79,075	79,075		79,075		79,075			19
20	Dues, Fees, Subscriptions & Promotions			58,537	58,537		58,537	(45,538)	12,999			20
21	Clerical & General Office Expenses	86,793	14,400	15,875	117,068		117,068	(1,029)	116,039			21
22	Employee Benefits & Payroll Taxes			410,756	410,756	8,687	419,443		419,443			22
23	Inservice Training & Education			1,633	1,633		1,633		1,633			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			6,919	6,919		6,919		6,919			25
26	Insurance-Prop.Liab.Malpractice			109,079	109,079		109,079		109,079			26
27	Other (specify):*											27
28	TOTAL General Administration	220,556	14,400	681,874	916,830	8,687	925,517	(46,567)	878,950			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,039,184	265,705	911,760	3,216,649		3,216,649	(44,543)	3,172,106			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DOBSON PLAZA **#0008136** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	40,612	
	REPAIRS & MAINTENANCE		0	
			0	40,612
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,791	
			0	1,791
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,273	
	ELECTRICITY		24,877	
	WATER		16,920	
	CABLE TV - LOBBY		0	
			0	77,070
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,622	
	PAINTING & DECORATING		4,833	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		19,085	
	ELEVATOR MAINTENANCE & REPAIR		6,391	
	OUTSIDE LABOR		18,173	
	EXTERMINATING SERVICE		2,516	
	FIRE SERVICE		7,699	
			0	
			0	
			0	61,319
7	**OTHER**			
	SCAVENGER		6,068	
	SECURITY SERVICE		0	6,068
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,800	4,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	858	
	LABORATORY & XRAY EXPENSE		12	
	PURCHASED SERVICES		713	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,216	
	PHARMACY CONSULTANT	XVIII B 39-2	1,879	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		0	
			0	7,678
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		303	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		1,862	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	24,413	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	105	26,683
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY		0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,840	
			0	3,840
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DOBSON PLAZA **#0008136** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		25	25
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,109	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	72,966	
			0	79,075
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	15,454	
	EMPLOYEE RECRUITMENT / WANT ADS	XIX F	5,835	
	CONTRIBUTIONS	VI 20 XIX F	632	
	DUES & SUBSCRIPTIONS	XIX F	60	
	LICENSES & PERMITS	XIX F	7,104	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	29,297	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	155	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	58,537
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		232	
	EQUIPMENT REPAIR & MAINTENANCE		2,528	
	OUTSIDE CLERICAL SERVICES		500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,029	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,586	
	MESSENGER SERVICE		0	
			0	15,875

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	155,898	
	UNEMPLOYMENT COMPENSATION	XIX D	13,649	
	WORKERS COMPENSATION INSURANCI	XIX D	47,453	
	HOSPITALIZATION INSURANCE	XIX D	157,109	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,128	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	501 PLAN EXPENSE	XIX D	32,519	
	CHICAGO HEAD TAX	XIX D	0	410,756
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,633	1,633
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,919	6,919
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		109,079	109,079
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 911,760

DOBSON PLAZA
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	125,262	PATIENT MEALS	97341
LESS SALES TAX	(748)	ADD EMPLOYEE MEALS	7300
NET FOOD	124,514	TOTAL MEALS/YEAR	104641
TOTAL PATIENT CENSUS	32,447	NET FOOD	124514
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	104641
TOTAL PATIENT MEALS	97341	COST PER MEAL	1.19
		TIME EMPLOYEE MEALS	7300
ADD # EMPLOYEE MEALS/DAY	20		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	8687
TOTAL EMPLOYEE MEALS	7300		

DOBSON PLAZA, INC.
PROFESSIONAL FEES
12/31/05

ALPHA DATA	DATA PROCESSING	6,109.30
KRUPNICK, BOKOR	ACCOUNTING	20,500.00
FGMK LLC	ACCOUNTING	2,700.00
MYRON TUSHBAI	ACCOUNTING	1,018.65
FROST RUTTENBERG ROTHBLATT	ACCOUNTING	300.00
RICHARD PEELO	MEDICARE CONSULTANT	3,000.00
HOGAN MARREN	LEGAL	4,250.00
SIGEL, ALBIN, LANDAU & RUBIN	LEGAL	7,500.00
PEDERSEN & HOUPT	LEGAL	14,604.00
KATTEN, MUCHIN,ZAVIS, ROSENMAN	LEGAL	1,009.92
ELISABETH SCHOENBERGER	LEGAL	4,650.00
RIEFF SCHRAMM KANTER	LEGAL	10,074.00
ADVANTAGE BENEFITS	501K PLAN ADMINISTRATOR	988.85
ECONOCARE	PURCHASING CONSULTANT	1,620.00
PERSONAL PLANNERS	UC CONSULTANT	750.00
		79,074.72

DOBSON PLAZA, INC,
TRANSPORTATION - STAFF
12/31/05 **ACCT #18370** (508003)

	NAME	DEPARTMENT	PURPOSE	MISC	AUTO ALLOW J GRODETZ
01/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
01/05	CITY OF EVANSTON	FACILITY		100.00	
02/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
02/05	FIRST CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	50.52	
03/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		161.54
03/05	FIRST CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	76.60	
04/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
04/05	FIRST CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	186.05	
05/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
05/05	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	218.15	
06/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
06/05	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	195.26	
07/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		484.62
07/05	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	146.71	
08/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
09/05	CHASE CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	342.77	
09/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
10/05	FIRST CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	471.15	
10/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
11/05	FIRST CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	175.87	
11/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
12/05	FIRST CARD	FACILITY	Gasoline for facilty banking, maintenance, marketing & activities	756.22	
12/05	PAYROLL - AUTO ALLOWANCE		AUTO ALLOWANCE		323.08
TOTAL				**2,719.30**	**4,200.04**
			TOTAL STAFF TRANSPORTATION:	**6,919.34**	

Facility Name & ID Number DOBSON PLAZA #0008136 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			71,578	71,578		71,578	8,621	80,199			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			344,275	344,275		344,275	(115,412)	228,863			32
33	Real Estate Taxes			119,481	119,481		119,481		119,481			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			535,334	535,334		535,334	(106,791)	428,543			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,116	12,853	64,969		64,969		64,969			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,108	53,108		53,108		53,108			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		52,116	65,961	118,077		118,077		118,077			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,039,184	317,821	1,513,055	3,870,060		3,870,060	(151,334)	3,718,726			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,621	30		9
10	Interest and Other Investment Income	(115,279)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(748)	2		13
14	Non-Care Related Interest	(133)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(155)	20		17
18	Fines and Penalties	(1,029)	21		18
19	Entertainment				19
20	Contributions	(632)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(15,454)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(29,297)	20		28
29	Other-Attach Schedule DEFERRED MAINTENANCE	2,772	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (151,334)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (151,334)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DOBSON PLAZA

ID# 0008136

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2,772	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,772		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOBSON PLAZA **#** 0008136 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(748)	0	0	0	0	0	0	0	0	0	0	(748)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,772	0	0	0	0	0	0	0	0	0	0	2,772	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	2,024	0	0	0	0	0	0	0	0	0	0	2,024	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(45,538)	0	0	0	0	0	0	0	0	0	0	(45,538)	20
21	Clerical & General Office Expenses	(1,029)	0	0	0	0	0	0	0	0	0	0	(1,029)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(46,567)	0	0	0	0	0	0	0	0	0	0	(46,567)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(44,543)	0	0	0	0	0	0	0	0	0	0	(44,543)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOBSON PLAZA # 0008136 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,621	0	0	0	0	0	0	0	0	0	0	8,621	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(115,412)	0	0	0	0	0	0	0	0	0	0	(115,412)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(106,791)	0	0	0	0	0	0	0	0	0	0	(106,791)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(151,334)	0	0	0	0	0	0	0	0	0	0	(151,334)	45

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	SEE ATTACHED					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN	ADMINISTRATOR	SUPERVISION	0.00	529,796	35	47.00	SALARY	$ 62,743	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 62,743		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB FINANCIAL		X	MORTGAGE		12/16/04	$ 5,500,000	$ 5,332,087	12/16/09	PRIME+	$ 331,932	1
2	TITLE & LOAN FEES		X	AMORTIZED OVER 5 YRS		12/16/04	17,760	14,208			3,552	2
3												3
4	NISSAN		X	AUTO LOAN	$549.87	03/04/03	29,883	14,228	02/04/08	3.9700	670	4
5	LEXUS		X	AUTO LOAN	$606.41	09/30/03	27,987	12,506	09/30/07		310	5
	Working Capital											
6	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	$4,318.21	12/10/04	51,818		11/10/05	3.6369	1,094	6
7	ABRAHAM SCHIFFMAN	X		INSURANCE FINANCING	$6,782.30	06/01/05	77,512	40,694	06/01/06	5.0000	1,615	7
8	NATIONAL REPUBLIC BK		X	WORKING CAPITAL	2333.00+INT	04/01/03	140,000	65,333		PRIME+	4,969	8
9	TOTAL Facility Related				$12,256.79		$ 5,844,960	$ 5,479,056			$ 344,142	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							133	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 133	14
15	TOTALS (line 9+line14)						$ 5,844,960	$ 5,479,056			$ 344,275	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number DOBSON PLAZA # 0008136 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	118,690	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	118,491	2
3. Under or (over) accrual (line 2 minus line 1).	$	(199)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	119,680	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	119,481	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	122,152	8
2001	112,367	9
2002	114,247	10
2003	117,516	11
2004	118,491	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOBSON PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0008136

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-113-043-0000	NURSING HOME	$ 116,415.67	$ 116,415.67
2.	10-25-220-015-0000	NURSING HOME	$ 2,075.77	$ 2,075.77
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,491.44	$ 118,491.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,536 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	7,728	1966	$ 80,506	1
2					2
3	TOTALS	7,728		$ 80,506	3

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1966	1966	$ 251,171	$	35	$	$	$ 251,171	4
5	33			1987	930,705	38,099	40	23,268	(14,831)	451,285	5
6	2			1971	11,147		8-12			11,147	6
7	4			1987	64,011		30	1,067	1,067	5,335	7
8											8
	Improvement Type**										
9	ELECTRICAL & PLUMBING			1976	1,027		8			1,027	9
10	SPRINKLER SYSTEM			1982	9,921		15			9,921	10
11	NURSING OFFICE			1982	891		15			891	11
12	RENOVATE NURSING STATION			1986	5,223		20	261	261	4,719	12
13	LANDSCAPING			1988	6,905		10			6,905	13
14	LAND IMPROVEMENTS - SEWER			1988	5,650		25	226	226	3,804	14
15	LAND IMPROVEMENTS - FENCING			1988	1,878		15			1,878	15
16	LAND IMPROVEMENTS - PAVING			1988	12,335		20	617	617	10,386	16
17	OUTSIDE SIGN			1988	2,473		12			2,473	17
18	SPRINKLER SYSTEM			1988	42,241		25	1,690	1,690	28,448	18
19	HEATING, VENTILATION, & A/C			1988	48,620		20	2,431	2,431	40,922	19
20	PLUMBING COMPOSITE			1988	63,062		25	2,522	2,522	42,957	20
21	ELECTRICAL WIRING			1988	115,484		20	5,774	5,774	97,196	21
22	BRICK-ENCLOSED GENERATOR			1989	1,375		25	55	55	853	22
23	FENCE - GENERATOR			1989	480		15	21	21	480	23
24	CATCH BASIN			1989	5,000		10			5,000	24
25	REMODELLING OF ANCILLARY AREAS			1997	534,985	16,180	40	13,374	(2,806)	120,366	25
26	CANOPY SIGN			1999	8,000	205	39	205		1,307	26
27	ELEVATOR REPAIR			1999	1,990	51	39	51		317	27
28	FIRE DAMPERS / AIR INTAKES			2000	10,515	382	27.5	382		2,149	28
29	ELEVATOR UPGRADE / AIR INTAKES			2000	28,259	1,028	27.5	1,028		5,269	29
30	ELEVATOR UPGRADE			2001	18,977	690	27.5	690		3,306	30
31	CARPETING			2001	25,597	2,253	10	2,560	307	11,520	31
32	HEAT EXCHANGER / FIRE SUPPRESSION SYSTEM			2003	11,572	421	27.5	421		1,149	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,219,494	$ 59,309		$ 56,643	$ (2,666)	$ 1,122,181	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 23,682	$ 969	$ 2,390	$ 1,421	8-10 YRS	$ 10,124	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	222,573				5-20 YRS	222,573	73
74								74
75	TOTALS	$ 246,255	$ 969	$ 2,390	$ 1,421		$ 232,697	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMIN, BANKING,	'98 LEXUS	1998	$ 68,441	$ 1,775	$ 1,775	$	4 YR	$ 7,100	76
77	ACTIVITIES,MAINT,	'95 JEEP	2001	19,087	1,775	4,771	2,996	4 YR	19,087	77
78	& PURCHASING,	'03 NISSAN	2003	30,491	2,950	7,623	4,673	4 YR	19,058	78
79	ETC	'01 LEXUS	2003	27,987	4,800	6,997	2,197	4 YR	10,495	79
80	TOTALS			$ 146,006	$ 11,300	$ 21,166	$ 9,866		$ 55,740	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,692,261	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 71,578	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 80,199	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,621	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,410,618	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DOBSON PLAZA | STATE OF ILLINOIS # 0008136 | Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 10,149	$		$ 10,149	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,584			2,584	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			120			120	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				38,655		38,655	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					13,461		13,461	13
14	TOTAL			$		$ 12,853	$ 52,116		$ 64,969	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DOBSON PLAZA # 0008136 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,289,241	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	628,967		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	62,554		7
8	Accounts Receivable (owners or related parties)	1,949		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,982,711	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,506		13
14	Buildings, at Historical Cost	2,082,284		14
15	Leasehold Improvements, at Historical Cost	166,742		15
16	Equipment, at Historical Cost	394,734		16
17	Accumulated Depreciation (book methods)	(1,460,769)		17
18	Deferred Charges	14,208		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): NY LIFE INSUR.CONTRACTS	160,769		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,438,474	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,421,185	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 146,195	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,432		28
29	Short-Term Notes Payable	106,027		29
30	Accrued Salaries Payable	90,065		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,344		31
32	Accrued Real Estate Taxes(Sch.IX-B)	119,680		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	174,260		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 660,003	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,734		39
40	Mortgage Payable	5,332,087		40
41	Bonds Payable			41
42	Deferred Compensation	382,244		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,741,065	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,401,068	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,979,883)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,421,185	$	48

***(See instructions.)**

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 106,258	1
2	Restatements (describe):		2
3	2004 IL REPLACEMENT TAX	(15,935)	3
4	ROUNDING	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 90,324	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	970,295	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,040,502)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,070,207)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,979,883)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,591,369	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,591,369	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	140,545	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 140,545	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	942	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 942	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	115,412	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 115,412	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,848,268	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	589,341	31
32	Health Care	1,710,478	32
33	General Administration	916,830	33
	B. Capital Expense		
34	Ownership	535,334	34
	C. Ancillary Expense		
35	Special Cost Centers	64,969	35
36	Provider Participation Fee	53,108	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	7,913	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,877,973	40
41	**Income before Income Taxes (line 30 minus line 40)****	970,295	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 970,295	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	998	1,062	$ 36,970	$ 34.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,560	23,894	641,468	26.85	3
4	Licensed Practical Nurses	5,276	5,704	123,226	21.60	4
5	CNAs & Orderlies	53,331	58,917	573,521	9.73	5
6	CNA Trainees					6
7	Licensed Therapist	520	524	13,635	26.02	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,133	2,485	38,235	15.39	9
10	Activity Assistants	2,333	2,474	30,639	12.38	10
11	Social Service Workers	866	872	20,978	24.06	11
12	Dietician					12
13	Food Service Supervisor	1,464	1,570	28,777	18.33	13
14	Head Cook	4,722	5,333	52,015	9.75	14
15	Cook Helpers/Assistants	559	577	3,945	6.84	15
16	Dishwashers					16
17	Maintenance Workers	6,378	7,319	59,137	8.08	17
18	Housekeepers	2,039	2,296	15,442	6.73	18
19	Laundry	7,827	8,512	60,205	7.07	19
20	Administrator	2,086	2,086	62,571	30.00	20
21	Assistant Administrator	2,086	2,124	71,192	33.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,771	5,560	86,793	15.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,962	2,228	23,191	10.41	31
32	Other Health C: ADMISSIONS/QA	4,549	5,065	97,244	19.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,460	138,602	$ 2,039,184 *	$ 14.71	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 40,612	1-3	35
36	Medical Director	O	4,800	9-3	36
37	Medical Records Consultant	N	4,216	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	1,879	10-3	39
40	Physical Therapy Consultant	L	24,413	10a-3	40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F	105	10a-3	43
44	Activity Consultant	E			44
45	Social Service Consultant	E	3,840	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 79,865		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	29	$ 858	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	29	$ 858		53

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLOTTE KOHN	ADMIN	**	$ 62,571
PAM SEEFURTH	ASST ADMIN	0	71,192
BY ATTRIBUTION 100% KOHN FAMILY OWNED			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 133,763

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		79,075
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 79,075

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 47,453
Unemployment Compensation Insurance		13,649
FICA Taxes		155,898
Employee Health Insurance		157,109
Employee Meals		8,687
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		4,128
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		32,519
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 419,443

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,835
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	44,751
TRUST/FRANCHISE/CONTRIB/ETC	787
LICENSES & PERMITS	6,904
DUES & SUBSCRIPTIONS	60
TRUST/FRANCHISE/CONTRIB/ETC	(787)
Less: Public Relations Expense	(0)
Non-allowable advertising	(15,454)
Yellow page advertising	(29,297)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,999

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2002	$ 1,677	3	$ 280	$ 559	$ 559	$ 279	$	$	$	$	$
2	PAINT/DECORATING	2003	9,666	3		1,611	3,222	3,222	1,611				
3	PAINT/DECORATING	2004	9,893	3			1,649	3,298	3,298	1,648			
4	PAINT/DECORATING	2005	4,833	3				806	1,611	1,611	805		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 26,069		$ 280	$ 2,170	$ 5,430	$ 7,605	$ 6,520	$ 3,259	$ 805	$	$

Facility Name & ID Number DOBSON PLAZA # 0008136 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,108**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,687** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees